KAMALA D. HARRIS
Attorney General of California
JAMES M. LEDAKIS
Supervising Deputy Attorney General
DESIREE I. KELLOGG
Deputy Attorney General
State Bar No. 126461
110 West "A" Street, Suite 1100
San Diego, CA 92101
P.O. Box 85266
San Diego, CA 92186-5266
Telephone: (619) 645-2996
Facsimile: (619) 645-2061
Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **JULIE ANN JOHNSON** **1009 NE Kamies Lane** **Ankeny, IA 50021** **Registered Nurse License No. 674139** Respondent.	Case No. 2013-613 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about February 21, 2006, the Board of Registered Nursing issued Registered Nurse License Number 674139 to Julie Ann Johnson (Respondent). The Registered Nurse License expired on August 31, 2011, and has not been renewed.

JURISDICTION

This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

3. Code section 118(b), provides in pertinent part, that the suspension, expiration, or forfeiture by operation of law of a license shall not deprive a board of its authority to institute or continue a disciplinary proceeding against the licensee during the period within which the license may be renewed, restored, reissued or reinstated.

4. Section 2750 of the Business and Professions Code ("Code") provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license.

6. Section 2811(b) of the Code provides, in pertinent part, that the Board may renew an expired license at any time within eight years after the expiration.

STATUTORY PROVISIONS

7. Section 2761 of the Code states:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct. . . .
>
> (1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.
>
> . . . .
>
> (4) Denial of licensure, revocation, suspension, restriction, or any other disciplinary action against a health care professional license or certificate by another state or territory of the United States, by any other government agency, or by another California health care professional licensing board.

A certified copy of the decision or judgment shall be conclusive evidence of that action.

...

8. Section 2762 of the Code states:

In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.

(b) Use any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, or any dangerous drug or dangerous device as defined in Section 4022, or alcoholic beverages, to an extent or in a manner dangerous or injurious to himself or herself, any other person, or the public or to the extent that such use impairs his or her ability to conduct with safety to the public the practice authorized by his or her license.

....

(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section.

REGULATORY PROVISIONS

9. Title 16, California Code of Regulations, section 1442, provides:

As used in Section 2761 of the code, "gross negligence" includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life.

10. Title 16, California Code of Regulations, section 1443, provides:

As used in Section 2761 of the code, "incompetence" means the lack of possession of or the failure to exercise that degree of learning, skill, care and

experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5.

11. Title 16, California Code of Regulations, section 1443.5, provides:

A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided.

DRUGS

12. Morphine Sulfate is a Schedule II controlled substance pursuant to Health and Safety Code section 11055(b)(1)(L) and is a dangerous drug pursuant to Business and Professions Code section 4022.

13. Propofol is an intravenous anesthetic agent and is a non-barbiturate sedative, used for the induction, maintenance of general anesthesia and sedation of ventilated adults receiving intensive care. It is a dangerous drug pursuant to Business and Professions Code section 4022.

COST RECOVERY

14. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case, with failure of the licentiate to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

FACTUAL ALLEGATIONS

15. On December 11, 2010, Respondent was employed as a registered nurse in the Intensive Care Unit at Mission Hospital in Laguna Beach, California. During her shift at Mission Hospital, Respondent withdrew 2 mg of Morphine Sulfate at 2139 hours from the Pyxis.[1] Respondent documented in the nursing notes that she administered 1 mg of the Morphine Sulfate at 2200 hours but did not document it in the MAR. However, she carried 1 mg of Morphine Sulfate in her pocket for approximately three hours until another nurse discovered the Morphine Sulfate in Respondent's pocket and had Respondent waste it. The Respondent also documented a neuro check for a patient at 0600 hours but left her shift at 0400 hours.

16. On December 12, 2010, Respondent was employed as a registered nurse in the Intensive Care Unit at Saddleback Memorial Medical Center in San Clemente, California. During her shift, Respondent speech was slurred and her gait was unsteady. She was repeatedly absent from her unit while a patient was assigned to her care and did not document care of her patient. Other nurses called the House Nursing Supervisor to assess Respondent. The House Nursing Supervisor determined that Respondent should be taken to the Emergency Department and called for a gurney. When the House Nursing Supervisor assisted Respondent onto the gurney, a bottle

[1] Pyxis is a trade name for the automatic single-unit dose medication dispensing system that records information such as patient name, physician orders, date and time medication was withdrawn, and the name of the licensed individual who withdrew and administered the medication. Each user/operator is given a user identification code to operate the control panel. Sometimes only portions of the withdrawn narcotics are given to the patient. The portions not given to the patient are referred to as "wastage." This waste must be witnessed by another authorized user and is also recorded by the Pyxis machine.

of Propofol and a syringe with white liquid fell out of Respondent's purse. The lot number for the Propofol that fell out of Respondent' purse was the same lot number as the stock of Propofol from the pharmacy at Saddleback Memorial Medical Center. Respondent withdrew 1 10 mg/ml IV 1000 MG vial of Propofol at 2234 from AcuDose[2] but did not document the administration or wastage of this vial.

17. On March 7, 2012, the Iowa Board of Nursing approved a Notice of Hearing, Statement of Charges, Settlement Agreement and Final Order (combined) from *In the Matter of Julie Ann Johnson*, Case No. 11-978. The Factual Circumstances section of the combined document recites that Respondent was employed as a travel nurse who was assigned to the Emergency Room at a hospital. On November 25, 2011, Respondent left her nursing assignment without advising staff of her whereabouts. Respondent was subsequently located in the restroom and after she exited, she exhibited "significant signs of impairment." Respondent admitted to misappropriating and self-injecting Propofol while on duty. She further admitted to the habitual use of opioids. Respondent's license to practice nursing in Iowa was indefinitely suspended pending evaluation from a Board-approved provider and until she can demonstrate twelve months of continuous sobriety. Her license was disciplined.

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct-Out of State Discipline)

18. Respondent is subject to disciplinary action under Code section 2761, subdivision (a)(4), on the grounds of unprofessional conduct in that Respondent was disciplined by the State of Iowa as set forth in paragraph 17.

[2] AcuDose is a trade name for the automated singe-unit dose medication dispensing system that records information such as patient name, physician orders, date and time medication was withdrawn, and the name of the licensed individual who withdrew and administered the medication. In the event that only portions of the withdrawn medication is given to the patient, the portions not given to the patient are referred to as wastage. This waste must be witnessed by another authorized user and is also recorded by the AcuDose machine.

SECOND CAUSE FOR DISCIPLINE

(Illegally Obtaining Controlled Substances)

19. Respondent is subject to disciplinary action under section 2762(a) of the Code in that Respondent illegally obtaining or possessing controlled substances, without a prescription, while employed as a registered nurse at Mission Hospital, Saddleback Memorial Medical Center and a hospital in Iowa as set forth in paragraphs 15-17, which are incorporated herein by reference herein.

THIRD CAUSE FOR DISCIPLINE

(Used Drugs in Dangerous Manner)

20. Respondent is subject to disciplinary action under section 2762(b) of the Code in that Respondent used controlled substances to an extent or in a manner that was dangerous to herself or others as described in the Factual Circumstances of the Notice of Hearing, Statement of Charges, Settlement Agreement and Final Order from *In the Matter of Julie Ann Johnson*, Case No. 11-978 in paragraph 17, above, which is incorporated herein by reference.

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct-Falsify or Make Grossly Incorrect or Inconsistent Entries)

21. Respondent is subject to disciplinary action for unprofessional conduct under Code section 2762(e) for falsifying or making grossly incorrect, inconsistent and/or unintelligible entries in the hospital records of Mission Hospital and Saddleback Memorial Medical Center by withdrawing medication, charging the withdrawal to patients who did not receive the drugs or for whom Respondent did not document administration or wastage of the drug as is more particularly set forth in paragraphs 15 -16 above, which are incorporated herein as though set forth in full.

FIFTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Gross Negligence)

22. Respondent is subject to disciplinary action for unprofessional conduct under section 2761(a)(1) of the Code in that during her assigned shifts at Mission Hospital and Saddleback Memorial Medical Center on December 11 and 12, 2010, Respondent was grossly negligent by failing to provide care which she knew or should have known would jeopardize a patient's life, as

is set forth in paragraphs 15 through 16, above, in that she possessed a controlled substance or dangerous drug and did not account for those medications while on duty and failed to document care and was repeatedly absent from her unit at Saddleback Memorial Medical Center.

SIXTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Incompetence)

23. Respondent is subject to disciplinary action for unprofessional conduct under section 2761(a)(1) of the Code in that during her assignment at Mission Hospital and Saddleback Memorial Medical Center on December 11 and 12, 2010, Respondent demonstrated incompetence in her care of patients, as she failed to exercise the degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse, when she possessed a controlled substance or dangerous drug and did not account for those medications and failed to document care and was repeatedly absent from her unit at Saddleback Memorial Medical Center, as is set forth in paragraphs 15 through 16 above, which are incorporated herein as though set forth in full.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 674139, issued to Julie Ann Johnson;

2. Ordering Julie Ann Johnson to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: FEBRUARY 13, 2013

for LOUISE R. BAILEY, M.Ed., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

SD2012704252/70659577.doc